Procedure

Fracture

Please send us a copy of the radiology report along with this form, **completed and signed in sections A, B and D**.

Hospitalization

Please send us this form **completed and signed in sections A, B, C and D.**

Disability (students aged 16-24 only)

Please send us this form **completed and signed in sections A, B, C and D**.

Death, dismemberment or loss of use

Please contact us at **1-877-886-5042** to find out the procedure to follow.

Other

Please send us this form, **completed and signed in sections A, B, C and D**.

Notes

a) Please provide us with receipts for all incurred expenses covered under this contract.

b) The documents will not be returned unless requested.

c) Please note that additional information may be necessary.

Desjardins Insurance
Life • Health• Retirement

Case postale 520, succ. Lévis,
Lévis (Québec) G6V 7E2

Accirance, Personal Accident Insurance

Claim Form

Print Reset

If you wish to make a claim, call us at **1-877-886-5042.**

Our offices are open Monday to Friday, from 8:00 a.m. to 5:00 p.m., except on statutory holidays.

Payment of benefits

If you are covered under more than one insurance plans (private or public), see section Coordination of benefits in your contract's General Conditions.

If you would like your payment to be deposited directly into your bank account*, please enclose a VOID personal cheque with your claim.

To find out more about who is entitled to benefits, see section Payment of benefits in your contract's General Conditions.

*If Desjardins Insurance is unable to deposit your payment directly into your bank account, payment will made by cheque.

A. Identification of contract holder

Last name	First name	Contract number

Address - No, street	City	Province	Postal code

Are the benefits under which this claim is submitted covered by another insurance plan (group or other)? ☐ **Yes** ☐ **No**

Name of company	Contract number	Name of primary insured	Certificate number

B. Claimant's statement

Name of injured insured	Date of birth YYYY MM DD	Age	Sex ☐ F ☐ M

Date of accident YYYY MM DD	Time of accident ☐ A.M. ☐ P.M.	Place of accident

Detailed description of the type and the circumstances of the accident – If needed, use a separate dated and signed sheet.

Name of injuries – If this is a fracture, please specify what exactly was fractured (bone or other).

Dates of hospitalization from YYYY MM DD to YYYY MM DD	Name of hospital

Name and address of physician's consulted

Name of educational institution, when applicable

Claimant's signature X **Date**

C. Physician's report – Fees charged for this statement are to be paid by the person concerned.

Date of first visit YYYY MM DD	Diagnosis of injury

Hospitalization	Date and hour of admission YYYY MM DD HOUR	Date and hour of release YYYY MM DD HOUR
Disability	Description	Total disability period from YYYY MM DD to YYYY MM DD

Was the above accident the cause of: the disability ☐ Yes ☐ No the hospitalization ☐ Yes ☐ No

Name and address of physician (please print)

Signature of physician X **Date**

D. Authorization to collect and communicate personal information

For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Insurance or its reinsurers: (a) to collect from any individual, legal entity or public or parapublic organization only the personal information they have about me that is needed to process my file. This information may be collected from third parties, including any health care professional or establishment, MIB, Inc., insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers; (b) to disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about me that is needed to manage my file; (c) to request, if applicable, an investigation report about me and to use the personal information contained in other files it may have that are now closed; (d) to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file; (e) to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits; (f) to provide a brief report on my personal information, including my health information, to MIB, Inc. This authorization also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my claim. A photocopy of this authorization is as valid as the original.

X		**X**	
Signature of contract holder	**Date**	**Signature of injured person (14 years old or older)**	**Date**